

General Information for Authorization

Org	1. 508						Service T	e Type 2. R				
							Client In	formation				
Name			3. CLIENT NAME					Client ID		4. 123456789WA		
Living Arrangements			5.					Referenc	e Auth#	6.	•	
							Provider	nformatio	1			
Reque	sting NP	l #	7. 1123456789					Requesti	ng Fax#	8. XXXXXXXXX		
Servicing NPI#			9. 1123456789					Name		10. SERVICING PROVIDER NAME		
Referr	ing NPI #	#	11. 1	123456	5789			Referring	Fax#	12. XXXXXXXXX		
Servic	e Start		13.							14. N/A		
Date:												
						Se	rvice Requ	est Informa	ation			
Descri	ption of s	ervice bei	ing red	queste	d:		•			,		
15. Ac	ditional	Respirat	ory S	ory Services			16. N/A	N/A 17. N/A				
	rial / NEA							19. N/A				
20. Co Qualif		I. National Code	22.	Mod			24. \$ Am Reques			25. Part # (DME Only)	26. Tooth or Quad #	
P)	HCPCS					N/A			N/A	N/A	
		7			Λ,							
									•			
			_									
		•						,				
					,	1		nformation				
			Diagnosi	s name	28.							
Place of service 29. 12												
30. Co	mments:							.*				

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The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. <u>HIPAA Compliance</u>: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD		ACTION ALL FIELDS N	IUST BE TYPED.				
	Org required	Enter the Num	ber that Matches the Progra	am/Unit fo	r the Request		
1		500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 515 - Transportation 516 - Miscellaneous					
	Service Type required	Enter the letter	(s) in all CAPS that represe	nt the ser	vice type you are requesting.		
2		BB Bath BEM Bath BEM Blood BGS Bone BP Breas BS Baria' C Commodification Cierce Cie	ear Implants ear Implant Ext Repl Prts node/Shower Chair ns ires al Nutrition Sitter/Feeder Seat tal Beds ng Aids Health ce on/Parental Therapy ent admission - ITA eation Illaneous al Nutrition	PHY PL PMR PROS PRS PSY PTL PWNF PWNF PHYS R RBS RE RLNS RM S SC SCAN SF SGD SSIP T	Orthopedic Shoes Orthotics PAS Duty Nursing Pharmacy Patient Lifts PM and R Prosthetics Prone Standers Psychotherapy Partial Power Wheelchair - Home Power Wheelchair - NF Power Wheelchair - NF Physician Services Respiratory Rebases Room equipment Relines Readmission Surgery Specialty Beds/Surfaces Shower chairs MRI/PET Scans Standing Frames Speech Generating Device Short Stay (In-Patient) Therapies (PT/OT/ST)		
		MWNF Manu O Other ODC Ortho ODME Other OOS Out o	dontic	TRN TU US V VNSS VOL WDCS	Transportation TENS Units Urinary Supplies Vision Vagus nerve stimulator surgery Inpatient admission-Voluntary Wound/decubiti care supplies		

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: Required.	 Enter the client ID = 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5.	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
´ 15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

Field	Name	Action	
	The second secon		S MUST BE TYPED
	Org required		imber that Matches the Program/Unit for the Request
		500 - Divisio	on of Alcohol and Substance Abuse (DASA)
		501 - Dental	
		502 - Durabl	le Medical Equipment (DME)
•		509 - Econor	mic Services Administration (ESA) (DSHS)
		504 Home	Health
		505 Hospic	ee
		506 - Inpatie	nt Hospital
1	•	507 Juveni	le Rehabilitation-Administration (JRA) (DSHS)
-		508 - Med	dical
		509 - Medie	cal Nutrition
		510 - Mente	
		511 - Outpt	
		1 -	al Medicine & Rehabilitation (PM & R)
		, ,	and Disability Services Administration (ADSA)
		515 Transp	· · · · · · · · · · · · · · · · · · ·
		516 Miscel	
	Service Type required	Enter the lett	ter(s) in all CAPS that represent the service type you are
	Jan 1200 - J. Pro 22 - January	requesting.	()
		1 0	
		AA	Ambulatory Aids
		BB	Bath Bench
		BEM	Bath-Equipment (misc)
		BGM	Blood Glucose Monitors
		BGS	Bone Growth Stimulator
		BP	Breast Pumps
		BS	Bariatric surgery
		BSS2	Bariatric surgery stage 2
		E	Commode
		CI	Cochlear Implants
		CIERP	Cochlear Implant Ext Repl-Prts
2		CSC	Commode/Shower Chair
		CWN	Crowns
		DASA	DASA
		DEN	Dentures
		EN	Enteral Nutrition
		ESA	ESA
		FSFS	Floor Sitter/Feeder Seat
		HB	Hospital Beds
		HEA	Hearing Aids Home Health
		HEDC	
		HSPC	Hospice Infusion/Perental Thorony
		IPT ITA	Infusion/Parental Therapy
		ITA IDA	Inpatient admission - ITA
		JRA LTAC	JRA LTAC
		LTAG	birro

Field	Name	Action	
		MG	Medication
		MISC	Miscellaneous
		MN	Medical Nutrition
		MWH	Manual Wheelchair Home
		MWNF	Manual Wheelchair - NF
		0	Other
		ODC	Orthodontic
		ODME	
			Other DME
	To a constant of the constant	OD	Out of State
		OP	Ostomy Products
		OS	Orthopedic Shoes
		OTC	Orthotics
		PAS	PAS
		PDN	Private Duty Nursing
		PHY	Pharmacy
		PL	Patient Lifts
		PMR	PM.and R
		PROS	Prosthetics
		PRS	Prone Standers
		PSY	Psychotherapy
		PTL	Partial
		PWH	Power Wheelchair - Home
		PWNF	Power Wheelchair - NF
		PWNF	Power Wheelchair - NF
		1	
		PHYS	Physician Services
		R	Respiratory
		RBS	Rebases
		RE	Room-equipment
		RLNS	Relines
		RM	Readmission
		S	Surgery
		SBS	Specialty Beds/Surfaces
	-	SC	Shower chairs
		SCAN	MRI/PET Scans
		SF	Standing Frames
		SGD	Speech Generating Device
		SSIP	Short Stay (In Patient)
	,	T T	
		TRN	Therapies (PT/OT/ST) Transportation
		i	Transportation
		TU	TENS Units
		US	Urinary Supplies
		¥	Vision
		VNSS	Vagus nerve stimulator surgery
		VO L	Inpatient admission Voluntary
		WDCS	Wound/decubiti care supplies
3	Name: Required.	Enter the la	st name, first name, and middle initial of the patient you
3	_		ng authorization for.
	Client ID: Required.		ient ID = 9 numbers followed by WA.

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5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc. NOT REQUIRED FOR RESPIRATORY SERVICES
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24	\$ Amount Requested: Required.	NOT REQUIRED FOR RESPIRATORY SERVICES SERVICES Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in

Field	Name	Action
		dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for	NOT REQUIRED FOR RESPIRATORY SERVICES Enter the
	all "By Report" codes requested.	manufacturer part # of the item requested.
	Tooth or Quad#: Required for	NOT REQUIRED FOR RESPIRATORY SERVICES
	dental requests	Enter the tooth or quad number as listed below:
		QUAD
		00 full mouth
		01 upper arch
26		02 lower arch
20		10 upper right quadrant
		20 upper left quadrant
		30 lower left quadrant
		40 lower right quadrant
		Tooth # 1-36, A. T., AS-TS, 51-82 and SN
27	Diagnosis Code:	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
		Use 12 for home
30	Comments:	Enter any free form information you deem necessary.

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